STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 1. 483.25(323)at J The Immediate Jeopardy began on 4/20/2017 when Resident #1 exited the facility unattended by the facility staff, and was found outside after a concerned citizen reported seeing a man walking with a wheelchair on the street outside of the facility. The Immediate Jeopardy was removed on 4/21/2017 at 5:00 pm when the facility completed in-servicing the staff on elopement policy and procedure. The facility also completed a review of all the residents who were at risk for elopement on 4/21/2017. The facility provided an acceptable plan of correction completed on 4/21/2017.	F 000		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		5/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/12/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation, the facility failed to prevent 1 of 3 sampled cognitively impaired resident with exit seeking behaviors from exiting the facility. A citizen found the resident on a busy street. The Resident #1 was not injured. The Immediate Jeopardy began on 4/20/2017 when Resident #1 exited the facility unattended by the facility staff, and was found outside after a concerned citizen reported seeing a man walking with a wheelchair on the street outside of the facility. The Immediate Jeopardy was removed on 4/21/2017 at 5:00 pm when the facility completed in-servicing the staff on elopement policy and procedure. The facility also completed a review of all the residents who were at risk for elopement on 4/21/2017. The facility provided an acceptable plan of correction completed on 4/21/2017. Findings included: Resident #1 was admitted to the facility on 4/12/2017. Resident's diagnoses included acute bronchitis, difficulty walking, muscle weakness, dementia with behavioral disturbance and hypertension. A review of the Nurse's note dated 4/13/2017 at 2:55 AM revealed "Resident noted to be alert with confusion. Very pleasant. Occasionally noted wandering around hallway, but not into other	F 323	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2	F 323		

residents' rooms. Noted resident has unsteady gait. Able to propel self in wheelchair."
A review of the Nurse's Note dated 4/14/2017 at 2:55 PM revealed "Resident compliant with care. Wandering in the halls after wife left. Verbalized wanting to go home."

A review of the Nurse's Note dated 4/17/2017 at 11:58 PM documented "Resident brought to facility after being in hospital for strengthening. Attended physical and occupational therapy today. Denies pain. Alert to person, confusion increases after the sun goes down and he begins to pack his belongings to leave. Redirected many times without incident. Wife in to visit this evening. Cooperative with care and redirection although he does not stay in one place for very long. Trying to get outdoors and banging on doors to see if they will open."
The admission Minimum Data Set (MDS) dated 4/19/2017 indicated Resident #1's cognitive status was moderately impaired and limited assistance of one person was required with transfers. The assessment further indicated the resident was independent with locomotion on the unit and used a wheelchair for locomotion. The resident was not coded for wandering behavior.

A review of the Nurse's Note dated 4/20/2017 at 8:28 PM read "Resident compliant with care. Wandering in halls after wife left. Verbalized wanting to go home."

A review of the Nurse's Note dated 4/20/2017 at 9:00 PM indicated "Occurrence Details: A concern citizen came to facility reported seeing a man walking with wheelchair out on the street outside of facility. Nurse #1 and Nurse Aide (NA) #1 got the resident back to the facility without a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3	F 323		

conflict. Upon investigation among staff, a new nurse on 400 hall. Nurse#1, let the resident out from 400 hall door thinking that resident is a visiting family member. Immediate Intervention: Resident was assessed, no obvious physical change noted. Wanderguard was put on resident. Q (every) 15 minutes visual check was implemented. A one-on-one sitter\NA was assigned to be with resident. Vitals: BP (blood pressure) 134/68 - 4/20/2017 08:38PM Pulse Type: Regular 18.0 - 4/19/2017 08:38 PM T (temperature) 97.3 - 4/18/2017 10:21 PM Route: Temporal Artery O2 (oxygen) 97.0 % - 4/14/2017 12:14PM Method: Room air. Resident's family/responsible party was notified of occurrence. Resident's family member was called at 9:50 PM explained the occurrence and situation surrounding elopement incident. The MD (medical doctor) was also notified at 9:55 PM. One on one sitter was provided for resident who is currently in room sleeping. Q 15 visual checks initiated this shift. Wanderguard was put on resident right after incident."

A review of the Nurse's Note date 4/20/2017 at 9:14 PM read "A concern citizen came to facility reported seeing a man walking with wheelchair out on the street outside of facility. Wound Care Nurse and Nurse Aide #1 got the resident back to the facility without conflict. Upon investigation among staff, a new nurse on 400 hall let the resident out from 400 hall door thinking that resident is a visiting family member. Per resident statement," I would like to go home but no one would give me a ride."

Interview with Nurse #2 on 4/4/2017 at 10:00 AM revealed on the night of 4/20/2017, she opened an exit door on 400 hall to let Resident #1 out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4	F 323		

thinking he was a family member. Nurse #2 stated the resident was carrying his belongings in the wheelchair and asked her to open the door so he can take his clothes to a family member. She added the resident did not have a wanderguard on and she did not recognize the resident thinking he was a family member. She further added she realized later that the person she had opened the door to let out of the building was a resident when a concerned citizen came at the facility at around 9:25 PM stating she had seen a person by the road and she was wondering whether it was one of their residents. Nurse # 2 further stated two other staff members got into their vehicles and went to 71st street to get the resident back to the facility. The Nurse further added she had been in-serviced in reference to not letting the residents out before verifying their identity

During the interview on 4/27/2017 at 10:30 AM, NA #1 who was assigned to the resident on 1st (7:00 AM to 3:00 PM) shift reported the resident always went to the exits and stated he wanted to go home to see his wife. She added the resident wandered throughout the building sometimes carrying his belongings in his wheelchair.

During the interview on 4/27/2017 at 10:45 AM, NA #2 who was working on the second shift but not assigned to Resident #1 reported she was sitting at the nurse's station when a lady knocked at the exit door on 200 hall at about 9:00 PM indicating she saw a man pushing a wheelchair by the main road and she was wondering whether that was a resident at the facility. NA #2 further indicated she left immediately in a vehicle with Nurse # 1 to go get the resident back to the facility after realizing Nurse #2 had opened the door letting the resident out of the building. NA#2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5	F 323		

indicated it had been about 15 minutes before she learned that Nurse #2 had let the resident out of the building. NA #2 further reported they found the resident by the busy street picking his belongings up which had dropped on the road.

During the interview on 4/27/2017 at 11:00 AM, Nurse #1 who was assigned to the resident on the night of 4/20/2017 indicated she was sitting at the nurse's station about 9:15 PM when she heard from another staff member that a lady had reported seeing a man who was identified as a resident walking by the main road. She reported she left with NA #2 to find the resident and bring him back to the facility. She added the resident always wandered around the facility and he would be found in other halls sometimes pushing his belongings in his wheelchair. Nurse #2 also stated on 4/20/2017 the day the resident exited the building at 9:00 PM she saw the resident at 8:00 PM for the last time during medication pass. She added the resident had no wander guard on the day he exited the building.

During the interview with the Minimum Data Set (MDS) nurse on 4/27/2017 at 4:00 PM, she reported she had not care planned the resident as an elopement risk because it had not been reported to her that the resident was wandering throughout the facility carrying his belongings and stating he wanted to go home. MDS also stated she did not review the nurse's notes which indicated the resident was an elopement risk because she depended on staff reporting to her about any observed behaviors by the resident. She also indicated if she knew about the resident's increase in wandering behavior after his admission assessment she would have initiated a care plan which would have indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6	F 323		

the use of a wanderguard and 15 minute checks on the resident. The MDS nurse also indicated on 4/12/2017, the day the resident was admitted, the resident scored a 2 on his elopement risk assessment which meant he was at low risk for elopement. She further indicated the resident scored a 16 on 4/20/2017 which meant he was at high risk for elopement on the day he exited the building.
During the interview on 4/28/2017 at 3:30 PM, Nurse #3 who was assigned to the resident on the third shift(11PM-7AM) reported the resident was a known wanderer and he was seen pushing his belongings throughout the facility and banging at doors trying to get out. She indicated the resident had no wander guard placed on him on the night he eloped but the wanderguard and 15 minute checks were implemented after the resident was brought back to the facility on 4/20/2017.

During the interview with the Administrator on 4/28/2017 at 4:00 PM, he indicated the staff notified him about Resident #1's elopement on the night he exited the building on 4/20/2017. He indicated it was Nurse #1 who failed to follow the elopement policy and procedure by letting the resident out of the building. He added the staff member had been disciplined and in-serviced about the elopement policy and procedure. He also indicated all the staff at the facility had been in-serviced in reference to the elopement policy and procedure. The Administrator also indicated following the elopement of the resident a wanderguard was placed on the resident and 15 minute checks of the resident was implemented. The Administrator also indicated his expectation would be for the staff to ask questions before letting the residents out. He further reported that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

the ongoing compliance was to monitor all residents with wanderguards on every shift beginning 4/20/2017. He further indicated the staff will continue to be in serviced and interviewed in reference to not letting the residents out before verifications. The administrator stated that the Director of Nursing and unit managers were going to be responsible for keeping up with residents who had wander guards at the facility.

The Nurse Aide who was assigned to Resident #1 on the second shift (3 PM-11PM) on 4/20/2017 was not available for an interview. The Nurse Aide was no longer employed at the facility.

Observation of the building on 4/28/2017 at 1:00 PM, revealed the main entrance doors were automatic doors. Further observations of the building revealed there were no alarms by the exit doors and the employees had a code that they had to use in order to exit the building. The facility parking lot was observed to be busy with vehicles coming and leaving, and the speed limit for the main road where the resident was found was 45 miles per hour. The temperature on 4/20/2017 at 9:25 PM was 72 degrees Fahrenheit.

The administrator was notified of the Immediate Jeopardy on 4/27/2017 at 5:35 PM.

The corrective action for past noncompliance dated 4/21/2017 included:
For the Resident Affected:
On 4/20/17 the facility was notified of a possible missing resident. Facility elopement protocol was initiated and a head count was completed. Resident #1 was found off the facility grounds and assisted back to the facility by staff. Upon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8	F 323		

arrival to the facility, a head to toe assessment was completed and no injuries were noted. Resident #1 was initially placed on 15 minute checks, however one on one supervision initiated within the hour. An elopement assessment was completed on 4/20/17 with a score of 16. A wander guard was applied. The care plan was updated to indicate an elopement risk. There was no negative outcome, harm or injury for resident #1. Resident was voluntarily discharged home with his wife on 4/27/17.

For other residents with the potential to be affected:
The staff member who unlocked the door for resident #1 was re-educated 1:1 on 4/21/17 by the DON and Administrator on verifying non-resident status prior to unlocking a door (asking questions), the elopement policy (including reporting exit seeking behaviors), location of wandering manuals and visitor/staff door policies. This individual received a disciplinary warning on 4/21/17 as well. Completed 4/21/2017.

All 100% staff members were re-educated 4/21/17 by DON/Administrator and/or designee on verifying non-resident status prior to unlocking doors, the elopement policy (including reporting exit seeking behaviors), location of wandering manuals and visitor/staff door policies. Completed on 4/21/2017.

Elopement assessments 100% were completed on 4/20/17 and 4/21/17 by the DON and designee for all residents to identify potential residents at risk for elopement. No residents were identified. Completed on 4/21/2017.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

Facility action plan to prevent re-occurrence:
An elopement assessment audit tool will be completed by the DON and/or designee for 3 months to ensure elopement assessments are completed accurately and thoroughly. The Elopement assessment audit tool will review new admissions and residents identified with exit seeking behaviors and verbalizations post admission. This audit will ensure the wander guard is placed, care plan is updated and elopement manual is updated as needed. To be completed thru 7/21/2017.
New hires will be educated on verifying non-resident status prior to unlocking doors, the elopement policy (including reporting exit seeking behaviors), and location of wandering manuals and visitor/staff door policies in every orientation class indefinitely. To be completed thru 7/21/2017.

The administrator and/or DON will randomly ask staff members 3 times per week how to verify non-resident status prior to unlocking doors for 3 months to be completed thru 7/21/2017.

A Quality Assurance Committee meeting was completed 4/21/2017.
The audits will be brought to the Quality Assurance Committee by the DON/Administrator for 3 months. Areas of continued concern will be brought back to the Quality Assurance Committee by the Administrator for further action plan. To be completed thru 7/21/2017 and ongoing if necessary.

As part of the validation process on 4/28/2017 at 4:30 PM, the entire plan of correction was reviewed including interviews of all staff related to identifying residents at risk for elopement,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345553	A. BUILDING _____ B. WING _____	C 04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF FAYETTEVILLE	**1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 ensuring placement and function of the wander guard. The staff was also aware of whom to report the elopement behaviors. A review of the monitoring tools revealed that the facility had completed the 100% in-service on 4/21/2017.	F 323		